

Hear what our moms are saying:

I think that this survey is a good idea. I am glad that I got to be a part of it. I hope that my answers and comments help others that are expecting or are having a new bundle of joy.



I was very disappointed at my prenatal care, the way they didn't care about when I wanted to get started on my prenatal care and very judgmental on my situation of being a young mother.

I hope that those surveys you are mailing out really count as a tool to come out with helpful programs to benefit those women who really need support during their pregnancy...

STAFF USE ONLY:

ID: _____

Date Received: ____/____/____

Date Entered: ____/____/____

Missing questions: _____

Need to telephone: ____ Yes ____ No Phone number: _____

Comments: _____

The OS ngeles ommy and aby Survey

**Your Voice, Your Experiences,
Our Healthy Mommies & Babies**



Take this survey
and get a
FREE
\$25
GIFT CARD
to
Ralphs/Food4Less

Look inside
for more coupons!

For more information, or to complete the survey by telephone, please call
the LAMB staff toll-free at 1-866-706-LAMB (1-866-706-5262)

Important Information About LAMB
Please Read Before Starting the Survey

- The Los Angeles Mommy and Baby Survey (LAMB) is a research project sponsored by the Los Angeles County Department of Public Health, Maternal, Child, and Adolescent Health Programs.
- We are asking women who live in Los Angeles County to answer the same questions. All of your names were picked by chance by a computer from recent birth certificates.
- It is your choice whether or not to do the survey. Whether or not you answer the survey will not affect your health care, immigration status, or any benefits you may be receiving.
- If you choose to do the survey, your answers will be kept private to the extent allowed by law and will be used only for research.
- Your name will not be used in any reports from LAMB. The survey has a number on it, so we will know when it is returned.
- Your answers will be linked to information on your baby's birth certificate to help us understand how your pregnancy experiences influence your baby's health. If you have had more than one baby, your answers may be linked to your other babies' birth certificates as well.
- Your answers will be grouped with those from other women. What we learn from this survey will be used to help mothers and babies in Los Angeles County.
- This is an ongoing study. We will keep your name and contact information so that we can contact you in a few years about participating in a follow-up study.

If you have questions about LAMB or if you want to answer the questions by telephone, please call 1-866-706-LAMB (1-866-706-5262)

LAMB CALENDAR

2009

JANUARY							FEBRUARY							MARCH							APRIL						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
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MAY							JUNE							JULY							AUGUST						
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SEPTEMBER							OCTOBER							NOVEMBER							DECEMBER						
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2010

JANUARY

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DECEMBER

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Frequently Asked Questions about LAMB

What is LAMB?

LAMB (Los Angeles Mommy and Baby Survey) is a project sponsored by the Los Angeles County Department of Public Health. Our survey asks mothers who recently had a baby questions about things that happened around the time of their pregnancy. Your answers will help us learn more about ways to improve the health of future mothers and babies.

Why should I participate in this survey?

LAMB is a very important survey that will help improve the health of future mothers and babies. The survey will help us to better understand and meet the health needs of Los Angeles County mothers and babies. Your answers will help us to improve services for women, infants, and families. To get a better overall picture of the health of mothers and babies in Los Angeles County, we need each mother selected to answer the questions.

Some of the questions do not seem related to pregnancy—why are they asked?

Many things in a mother's life may affect her pregnancy. These questions try to get the best picture of things that happened before, during, and after pregnancy. The questions also allow us to group you with other women. Although some of the questions may be personal, please remember that all your answers will be kept private.

How was I chosen to participate in LAMB?

Your name was picked by chance, like in a lottery, from the state birth certificate registry. You are one of a small number of women who were chosen to help us in this study.

Will I receive results of the survey?

If you would like us to send you the results of the survey, please tell us at the end of the survey.

What if I want to ask more questions about LAMB?

We will be happy to answer any other questions that you may have about LAMB. Please call us at 1-866-706-LAMB (1-866-706-5262). If you prefer to complete the survey on the telephone, please call us at the same number.

Today's Date

____/____/____

month day year

Your Date of Birth

____/____/____

month day year

Think about the time **before** you got pregnant with your new baby. Questions 1-23 ask about things that may have happened to you just **before** your last pregnancy.

1. Just **before** your last pregnancy, did you have health insurance?

Yes☐1

No☐0 → GO TO QUESTION #3
2. What kind of health insurance did you have **before** your last pregnancy?

Medi-Cal☐1

Private Insurance☐2

Other☐3

Please tell us: _____
3. During the **six months before** you got pregnant with your new baby, did you talk to a doctor, nurse or other health care worker about how to prepare for a healthy pregnancy and baby?

Yes☐1

No☐0 →GO TO QUESTION #5
4. Tell us why you saw a doctor, nurse, or other health care worker to prepare for this baby. **Check all that apply.**

I thought talking with a doctor or nurse would help me have a healthy pregnancy☐1

I had a chronic medical problem☐2

- I had problems during my previous pregnancy☐3

I expected to get pregnant☐4

I was encouraged to see a doctor or nurse☐5

→ GO TO QUESTION #6
5. Tell us why you did not see a health professional to prepare for this baby. **Check all that apply.**

I knew how to prepare myself for pregnancy already☐1

I didn't expect to get pregnant☐2

I didn't have enough money or insurance to pay for a check-up☐3

I didn't have a regular doctor or nurse to talk to☐4

I had no way to get to the clinic or the doctor's office☐5

I couldn't take time off from work☐6

I had no one to take care of my children☐7

I had too many other things going on☐8

I couldn't find a doctor or nurse who spoke my language☐9

Other☐10

Please tell us: _____

→ GO TO QUESTION #8
- ☐ Check here if you want someone to call you to do the survey over the telephone.

In the spaces below, please write your name, address, and telephone number and the name, address, and telephone number of a friend or family member who would know how to reach you in case you move. We ask for this in case we need to reach you to clarify answers on your survey and to make sure we have your current address to mail your Ralphs/Food4Less gift card. You will receive a Ralphs/Food4Less gift card whether you mail in your survey or take it over the telephone.
- ☐ If you will be moving to a new address, please write your new address and check here.

Your name: _____

Address: _____

Phone: () _____

When is the best time to call you? _____

Friend/family name: _____

Address: _____

Phone: () _____
-
- **Attention LAMB Staff: Tear out this page before entering data**
- 2
- 23

This is the end of the survey.

Please place the survey in the pre-addressed, postage-paid envelope that is provided and mail it to:

**Los Angeles Mommy and Baby Survey
Maternal, Child and Adolescent Health Programs
600 S. Commonwealth, Suite 800
Los Angeles, CA 90005**

Thank you very much for your help.

Your valuable contribution will help us make
Los Angeles County mothers and babies healthier!

** You will receive your \$25 Ralphs/Food4Less Gift Card in about
2 to 3 weeks after we receive your survey.

6. Where did you go to talk to a doctor, nurse or other health care worker about how to prepare for pregnancy? **Check all that apply.**
- Private doctor’s office☐1
- Health Maintenance Organization (HMO) For example, Kaiser☐2
- Community clinics/free clinics☐3
- Family planning clinics☐4
- Other sites☐5
7. Think about the times you saw a doctor or nurse in the **six months before** you got pregnant. Did your provider talk to you about these topics to get you ready for pregnancy?
- a. Multivitamin☐Y ☐N
- b. Healthy weight for pregnancy☐Y ☐N
- c. Immunizations☐Y ☐N
- d. Nutrition (Eating healthy)☐Y ☐N
- e. Stop smoking☐Y ☐N
- f. Taking care of your blood sugar☐Y ☐N
- g. Taking care of your blood pressure☐Y ☐N
- h. Taking care of your medical conditions (e.g. asthma, anemia)☐Y ☐N
- i. Taking care of your gums and teeth☐Y ☐N
- j. Domestic violence☐Y ☐N
- k. Anxiety or depression☐Y ☐N
- l. Birth control☐Y ☐N
- m. Genetic screening☐Y ☐N
- n. Lead and/or mercury exposure☐Y ☐N

8. In the **six months before** you got pregnant, did you have any of these problems? **Check all that apply.**
- Depression☐1
- Anxiety☐2
- High blood pressure (hypertension) ...☐3
- High blood sugar (diabetes)☐4
- Anemia (poor blood, low iron)☐5
- Heart problems☐6
- Problems with your gums or teeth ...☐7
- Asthma☐8
- Eat less than you felt you should because there wasn’t enough money to buy food☐9
9. In the **six months before** you found out you were pregnant with your new baby, how many cigarettes did you smoke a day, on average? (A pack has 20 cigarettes.)
- I didn’t smoke then☐1
- Less than 1 cigarette☐2
- 1 to 5 cigarettes☐3
- 6 to 10 cigarettes☐4
- 11 to 20 cigarettes☐5
- 21 to 40 cigarettes☐6
- 41 cigarettes or more☐7

10. During the **month before** you got pregnant with your new baby, how many times a week did you take a vitamin pill with folic acid or multivitamins?
- I did not take one at all☐1
- Once in a while☐2
- 1 to 3 times a week☐3
- 4 to 6 times a week☐4
- Everyday of the week☐5
11. Some health experts say you should take folic acid before and during early pregnancy. Below is a list of possible reasons for taking folic acid. **Check all that apply.**
- To make strong bones☐1
- To prevent birth defects☐2
- To prevent high blood pressure☐3
- To prevent anemia☐4
- I don't know☐5
12. Think about the time **three months before** you got pregnant. Were you trying to get pregnant? **Check one answer.**
- Yes☐1
- Yes, but was not trying very hard☐2
- No, I was trying hard to keep from getting pregnant☐3
- I wasn't trying to get pregnant or trying to keep from getting pregnant ..☐4

13. When you got pregnant with your new baby, were you using any method of birth control?
- Yes, all the time ...☐1 } → **GO TO QUESTION #14**
- Yes, sometimes ...☐2 }
- No☐3 → **GO TO QUESTION #15**
14. What were you or your husband or partner doing to keep from getting pregnant? **Check all that apply.**
- Pill☐1
- Condoms☐2
- Shots (Lunelle® or Depo-Provera®) ..☐3
- Patch (OrthoEvra®)☐4
- Rhythm method or natural family planning☐5
- Withdrawal (pulling out)☐6
- Vaginal ring (Nuva Ring®)☐7
- IUD (Mirena® or ParaGard®)☐8
- Other☐9
- Please tell us:** _____
- **GO TO QUESTION #16**

92. What was your family income in **2009** before taxes? Please check the number below that includes your total family income, including your income and the income of your husband or partner (if living with you in **2009**) and your children.
- Please include income from all sources, including jobs, welfare, disability, unemployment, child support, interest, dividends, and support from family members.**
- | | |
|---|--|
| Less than \$20,000 <input type="checkbox"/> 1 | \$60,000-\$99,999 <input type="checkbox"/> 4 |
| \$20,000-\$39,999 <input type="checkbox"/> 2 | More than \$100,000 <input type="checkbox"/> 5 |
| \$40,000-\$59,999 <input type="checkbox"/> 3 | I don't know <input type="checkbox"/> 89 |
93. How many people lived on this income in **2009**?
- _____ Total number of people

If you would like to write any comments about this survey, your prenatal care experiences, your pregnancy, or anything else, please do so in the space below.

The question below asks you about your feelings and thoughts during the last month. In each case, please mark how often you have felt or thought a certain way.

85. In the last month, how often have you felt:

	Never	Almost Never	Sometimes	Fairly Often	Very Often
a. You were unable to control the important things in your life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Confident about your ability to handle your personal problems?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. That things were going your way?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The next questions give us a general idea of the types of people who have taken part in this important survey. Again, all information about you will be kept private.

86. How tall are you?
_____ Feet and _____ Inches

OR
_____ Centimeters

87. Just before you got pregnant with your new baby, how much did you weigh?

_____ Pounds

OR
_____ Kilos

88. Just before you gave birth to your new baby, how much did you weigh?

_____ Pounds

OR

_____ Kilos

89. Were you born in the United States?
Yes ☐1

No ☐0

If no, please tell us where you were born:

90. How long have you lived in the United States?

_____ Years OR _____ Months

91. What language do you usually speak at home? Check all that apply.

English ☐1

Spanish ☐2

Asian language ☐3

Please tell us: _____

Other language ☐4

Please tell us: _____

15. What were your or your husband or partner’s reasons for not doing anything to keep from getting pregnant? Check all that apply.

I didn’t mind if I got pregnant ☐1

I wanted to have a baby/
I was trying to get pregnant ☐2

I thought I would not get
pregnant then ☐3

I had side effects from the
birth control method I was using ☐4

I had problems getting
birth control when I needed it ☐5

I thought my husband or partner
or I could not get pregnant ☐6

My husband or partner
did not want to use anything ☐7

I could not afford birth control ☐8

Other ☐9

Please tell us: _____

16. Before you got pregnant with your new baby, had you ever used emergency contraception (the “morning-after pill”)?

No ☐1

No, I didn’t know what emergency
contraception was ☐2

Yes ☐3

How many times? _____

17. Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Check one answer.

I wanted to be pregnant sooner ☐1

I wanted to be pregnant later ☐2

I wanted to be pregnant then ☐3

I didn’t want to be pregnant then
or at any time in the future ☐4

18. Just before you got pregnant with your new baby, how did your husband or partner feel about you becoming pregnant?

He wanted me to be pregnant sooner ☐1

He wanted me to be pregnant later ☐2

He wanted me to be pregnant then ☐3

He didn’t want me to be pregnant
then or at any time in the future ☐4

I didn’t have a husband or partner ☐5

I don’t know ☐6

19. How did you feel when you found out you were pregnant with your new baby? Were you:

Very unhappy ☐1

Somewhat unhappy ☐2

Neither happy nor unhappy ☐3

Somewhat happy ☐4

Very happy ☐5

20. Did a doctor help you become pregnant with your new baby (such as fertility-enhancing drugs, insemination, or in-vitro fertilization)?

Yes ☐1

No ☐0

21. **Before** you were pregnant with your new baby, how many times had you been pregnant? **Please include ALL pregnancies, even those that were miscarried or aborted.**

_____ Times

22. **Before** your new baby was born, how many times had you given birth? **Please include babies who died before delivery (stillbirths), but DO NOT count miscarriages and abortions.**

_____ Times _____ Total number of children

What are their ages?

23. **Before** your last pregnancy, did you ever have the following?

a. A baby that was born too soon (more than 3 weeks before its due date) ... ☐Y ☐N

b. A baby that weighed 5 pounds 8 ounces (2.5 kilos) or less at birth ... ☐Y ☐N

c. Miscarriage (a baby who died before 20 weeks of pregnancy) ☐Y ☐N

d. Abortion ... ☐Y ☐N

e. Stillbirth (a baby who died before delivery) ... ☐Y ☐N

f. A baby under 1 year old who passed away ... ☐Y ☐N

g. A baby born with a birth defect ☐Y ☐N

Please tell us what defect(s) your baby (babies) had:

Now think about things that happened to you when you were pregnant with your new baby.

24. Pregnancy can be a difficult time for some women. These next questions are about events that may have happened to you **during** your last pregnancy. Check **Y (Yes)** if it did or check **N (No)** if it did not. *It may help to look at the calendar on the back of the survey.*

a. A close family member was very sick and had to go into the hospital ... ☐Y ☐N

b. I got separated or divorced from my husband or partner ... ☐Y ☐N

c. I moved to a new address ... ☐Y ☐N

d. I was homeless ... ☐Y ☐N

e. My husband or partner lost his job ... ☐Y ☐N

f. I lost my job even though I wanted to go on working ... ☐Y ☐N

g. I argued with my husband or partner more than usual ... ☐Y ☐N

h. I had a lot of bills I could not pay ... ☐Y ☐N

i. I was in a physical fight ... ☐Y ☐N

j. My husband or partner or I went to jail ... ☐Y ☐N

k. Someone very close to me had a problem with drinking or drugs ☐Y ☐N

l. Someone close and important to me died ... ☐Y ☐N

m. I was in a car accident ... ☐Y ☐N

n. Other serious events happened during my pregnancy ... ☐Y ☐N

82. Tell us how strongly you agree or disagree with the following statements about this neighborhood. Answer for the neighborhood you lived in for the **most** time during your pregnancy.

Do you agree that people in your neighborhood:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
a. Are willing to help their neighbors?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. This is a close-knit (tight) neighborhood?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Can be trusted?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Generally don't get along with each other?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Do not share the same values?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

83. How often do your neighbors:

Never	Almost Never	Sometimes	Fairly Often	Very Often
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
a. Do favors for each other?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Ask each other advice about personal things such as child rearing or job openings?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Have parties or other get-togethers where other people in the neighborhood are invited?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Visit in each other's homes or on the street?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Watch over each other's property?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

84. How would you rate this neighborhood in terms of its:

Very Poor	Poor	Neutral	Good	Very Good
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
a. Police protection?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. Protection of property?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Safety from violence?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Friendliness?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Cleanliness?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Quietness?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Quality of schools?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
h. Availability of parks, playgrounds, or sidewalks?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
i. Municipal services (e.g., trash pickup, road repair, libraries, water)?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
j. Availability of places to buy fresh fruits and vegetables when you want them?				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

80. Have you ever experienced discrimination (for example, been prevented from doing something, or been hassled or made to feel inferior) in any of the following situations because of **your race or skin color, immigration status, age, income, because you are a woman, because you were pregnant, or language?** Check all that apply.

[illegible]

These next questions are about the neighborhood where you were living during your last pregnancy. Answer for the neighborhood you lived in for the most time during your pregnancy.

81. For how long have you lived in this neighborhood? Please count the **total** number of months or years **before and during** your last pregnancy that you have lived in this neighborhood.

____ Years **OR** ____ Months

25. Below is a list of ways you might have felt **during** your last pregnancy. For each question, select one of the following choices: Never, Occasionally, Fairly Often, Always.

How much of the time **during** your last pregnancy had you:

	Never	Occasionally	Fairly Often	Always
a. Been a very nervous person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. Felt calm and peaceful?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Felt sad?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Been a happy person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. Been upset because of something that happened unexpectedly?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f. Felt that you were unable to control the important things in your life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g. Felt that things were going your way?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
h. Felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
i. Felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

26. Below is a list of statements dealing with your feelings about yourself **during** your last pregnancy. For each item below, choose one from the following:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
a. I feel that I'm a person of worth, at least on an equal plane with others.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. I am able to do things as well as most other people.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. On the whole, I am satisfied with myself.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. I have little control over the things that happen to me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. There is really no way I can solve some of the problems I have.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Sometimes I feel that I am being pushed around in life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. I can do just about anything I really set my mind to do.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

27. **During** your last pregnancy, did you work outside your home?

Yes . . . ☐1

If you stopped working before you had your baby, which week of your pregnancy did you stop?

_____ Week

No . . . ☐1 → IF NO, GO TO QUESTION #29

28. **During** your last pregnancy, did you do any of the following regularly at work? For each item, check **Y (Yes)** if you did or **N (No)** if you did not.

- a. Worked more than 40 hours per week? . . . ☐Y ☐N
- b. Stood or walked for more than 3 hours a day? . . . ☐Y ☐N
- c. Lifted or carried more than 25 pounds? . . . ☐Y ☐N
- d. Worked a night shift or overnight shift at least once a week? . . . ☐Y ☐N

29. Many women find the **last three months** of pregnancy difficult. Think about how active you were during that time. How often did you exercise for 30 minutes or more? (For example, walking for exercise, swimming, cycling, dancing, or gardening.) Do not count exercise you may have done as part of your regular job.

- I didn't exercise . . . ☐1
- I didn't exercise; a doctor, nurse, or health care worker said not to exercise . . . ☐2
- Less than 1 day per week . . . ☐3
- 1 to 4 days per week . . . ☐4
- 5 or more days per week . . . ☐5

30. On average, how many cigarettes did you smoke per day **after** you found out that you were pregnant? (A pack has 20 cigarettes.)

- I didn't smoke then . . . ☐1
- Less than 1 cigarette . . . ☐2
- 1 to 5 cigarettes . . . ☐3
- 6 to 10 cigarettes . . . ☐4
- 11 to 20 cigarettes . . . ☐5
- 21 to 40 cigarettes . . . ☐6
- 41 cigarettes or more . . . ☐7

31. **During** your last pregnancy, about how many hours a day, on average, were you in the same room with someone who was smoking?

_____ Hours

32. Did you use any of these drugs when you were pregnant? For each item, check **Y (Yes)** if you did or check **N (No)** if you did not.

- a. Prescription drugs not prescribed by your doctor . . . ☐Y ☐N
- b. Over-the-counter medications ☐Y ☐N
- c. Marijuana (pot, weed) or hashish (hash) . . . ☐Y ☐N
- d. Amphetamines (uppers, ice, speed, crystal, crank) . . . ☐Y ☐N
- e. Cocaine (rock, coke, crack) or heroin (smack, horse) . . . ☐Y ☐N
- f. Tranquilizers (downers, ludes) or hallucinogens (LSD/acid, PCP/angel dust, ecstasy) . . . ☐Y ☐N
- g. Sniffing gasoline, hairspray, or other aerosols to get high . . . ☐Y ☐N

72. This question is about things that may have happened **after** your baby was born. For each item, check **Y (Yes)** if it did or check **N (No)** if it did not.

- a. Your husband or partner pushed, hit, slapped, kicked, choked, or physically hurt you in any way . . . ☐Y ☐N
- b. Your husband or partner tried to control your daily activities, for example telling you who you could talk to or where you could go . . . ☐Y ☐N
- c. You felt afraid of your husband or partner . . . ☐Y ☐N
- d. Your husband or partner repeatedly called you names, told you that you were worthless, ugly, or verbally threatened you . . . ☐Y ☐N
- e. Your husband or partner forced you to take part in any sexual activity when you did not want to (including touch that made you uncomfortable) . . . ☐Y ☐N

73. In the months **after** your new baby was born, would you say that you were:

- Not depressed at all . . . ☐1
- A little depressed . . . ☐2
- Moderately Depressed . . . ☐3
- Very Depressed . . . ☐4

74. Are you or your husband or partner doing anything **now** to keep from getting pregnant?

- Yes . . . ☐1
- No . . . ☐0

75. Are you or any other family member **currently** reading or looking at books with your baby?

Yes . . . ☐1 → GO TO QUESTION #77

No . . . ☐0

76. If you or other family members are not currently looking at books with your new baby, at what age do you think you will start reading or looking at books with your new baby?

- 3-11 months old . . . ☐1
- 1-2 years old . . . ☐2
- 3-4 years old . . . ☐3
- 5 and older . . . ☐4
- I probably will not read to my baby/child . . ☐5

→ GO TO QUESTION #78

77. **During** the past week, how many days did you or other family members read or look at books with your baby?

- Did not read to the baby this week . . . ☐0
- 1-3 days this week . . . ☐1
- 4-7 days this week . . . ☐2

This next section is going to ask about how you and others like you are treated, and how you typically respond.

78. If you feel you have been treated unfairly, do you usually: (please select the best response)

- Accept it as a fact of life . . . ☐1
- Try to do something about it . . . ☐2

79. If you have been treated unfairly, do you usually: (please select the best response)

- Talk to other people about it . . . ☐1
- Keep it to yourself . . . ☐2

68. Did any of these things keep your baby from having a well-baby checkup? **Check all that apply.**

- I couldn't get an appointment ☐1
- My baby was too sick to go for routine care ☐2
- I didn't have enough money or insurance to pay for a check-up ☐3
- Other ☐4

Please tell us: _____

69. **After** your baby was born, did you go back to a doctor or clinic for a postpartum checkup for yourself? (A postpartum checkup is a regular health visit for the mother, usually at 6 weeks after delivering the baby.)

- Yes ... ☐1 → GO TO QUESTION #71
- No ... ☐0

70. What were the reasons you didn't go see a doctor or nurse for a postpartum checkup? **Check all that apply.**

- I felt fine ☐1
- I didn't think I needed a check-up ... ☐2
- I didn't have enough money or insurance to pay for a check-up ☐3
- I had too many things going on ☐4
- I was too busy with my baby ☐5
- Other reason ☐6

Please tell us: _____

→ GO TO QUESTION #72

71. **During** the checkup, did your doctor or nurse talk to you about any of the following? **Check all that apply.**

- a. Birth control ☐Y ☐N
- b. Breastfeeding ☐Y ☐N
- c. Baby's sleeping position ☐Y ☐N
- d. Losing the weight
I gained during ☐Y ☐N
- e. Taking care of my blood sugar ☐Y ☐N
- f. Taking care of my
blood pressure ☐Y ☐N
- g. Domestic violence/child abuse . ☐Y ☐N
- h. Anxiety ☐Y ☐N
- i. Depression ☐Y ☐N
- j. Stopping smoking ☐Y ☐N
- k. Stopping drinking alcohol ... ☐Y ☐N
- l. Stopping drug use ☐Y ☐N
- m. Childhood lead exposure ☐Y ☐N

33. Did you drink any alcohol **during** your last pregnancy? For example, beer, wine, wine cooler, liquor, or a mixed drink made with liquor.

- Yes ☐1
- No ☐0

34. Some women find pregnancy a difficult time financially. While you were pregnant, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- Yes ☐1
- No ☐0

The next questions (35–38) are about your relationship with the baby's father or your partner.

35. At the time your baby was born, what was your relationship status with the baby's father?

- Married ☐1
- Separated or divorced ☐2
- Widowed ☐3
- Never married but living together ... ☐4
- Never married and living apart ☐5

36. How **often** did you have open disagreements with the father about the following things?

- a. Money
☐NEVER ☐SOMETIMES ☐OFTEN
- b. Spending some time together
☐NEVER ☐SOMETIMES ☐OFTEN
- c. Sex
☐NEVER ☐SOMETIMES ☐OFTEN
- d. Drinking or drug use
☐NEVER ☐SOMETIMES ☐OFTEN
- e. Being faithful
☐NEVER ☐SOMETIMES ☐OFTEN

37. **During** your last pregnancy, did the baby's father or your partner do any of the following for you?

- a. Gave me money or bought things for me ☐Y ☐N
- b. Helped me in other ways, such as taking me to the doctor or helping with chores ☐Y ☐N
- c. Gave me emotional support in labor ☐Y ☐N
- d. Visited the baby and me at the hospital after the delivery ... ☐Y ☐N
- e. Wanted to put his name on the baby's birth certificate as the father ☐Y ☐N
- f. Said he wanted to help me raise my child in the coming years ☐Y ☐N
- g. Hit or slapped me when he was angry ☐Y ☐N
- h. Insulted or criticized me or my ideas ☐Y ☐N
- i. The baby's father threatened me or made me feel unsafe in some way ☐Y ☐N
- j. I was frightened for my safety or the safety of my family because of his anger or threats ☐Y ☐N
- k. He tried to control my daily activities, for example, telling me who I could talk to or where I could go ☐Y ☐N
- l. He forced me to take part in any sexual activity when I did not want to (including touch that made me uncomfortable) ☐Y ☐N

38. Overall, how satisfied were you with the support given by your baby’s father **during** your most recent pregnancy? **Check one answer.**

- Not at all satisfied□1
- Somewhat dissatisfied□2
- Neither dissatisfied nor satisfied (neutral)□3
- Somewhat satisfied□4
- Very satisfied□5
- Not applicable□6

39. **During** your last pregnancy, would you be able to get these kinds of support, if you needed them?

- a. Someone to loan me \$50□Y □N
- b. Someone to help me if I were sick and needed to be in bed...□Y □N
- c. Someone to take me to the clinic or doctor if I needed a ride ...□Y □N
- d. Someone to give me a place to live□Y □N
- e. Someone to help me with babysitting or child care□Y □N
- f. Someone to help me with household chores□Y □N
- g. Someone to talk to about my problems□Y □N

The next questions are about the checkups and advice about pregnancy you received during your last pregnancy. *It may help to look at the calendar on the back of the survey when you answer these questions.*

40. How many weeks or months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC (the Special supplement Nutrition Program for Women, Infants, and Children).

_____ Weeks **OR** _____ Months

☐ I didn’t go for prenatal care

↳ GO TO QUESTION #48

41. Where did you go for your prenatal care? **If you went to more than one place for prenatal care, answer for the place where you got most of your care.**

- Private doctor’s office□1
- Health Maintenance Organization (HMO) For example, Kaiser□2
- Community clinics/free clinics□3
- Family planning clinics□4
- Other sites□5

42. Did you get prenatal care as early in your pregnancy as you wanted?

- Yes ...□1 → GO TO QUESTION #44
- No ...□0

60. What were your reasons for stopping breastfeeding? **Check all that apply.**

- I had difficulty nursing my baby□1
- Breast milk alone did not satisfy my baby□2
- I thought I was not making enough milk□3
- My nipples were sore, cracked, or bleeding□4
- I went back to work or school□5
- I did not like breastfeeding□6
- My family and/or partner did not want me to breastfeed□7
- Other□8

Please tell us: _____

61. Did a doctor or nurse give you any help or encouragement for breastfeeding?

- a. During prenatal visits□Y □N
- b. In the hospital after your baby was born□Y □N
- c. During the well-baby checkup□Y □N

62. How do you put your new baby down to sleep **most** of the time? **Check one answer.**

- On his/her side□1
- On his/her back□2
- On his/her stomach□3

63. How **often** does your new baby sleep in the same bed with you or anyone else?

- 1 Always
 - 2 Frequently
 - 3 Sometimes
 - 4 Rarely
 - 5 Never
- } → GO TO QUESTION #64
- } → GO TO QUESTION #65

64. What are the reasons your baby sleeps with you or with another person? **Check all that apply.**

- I do not have a crib for my baby□1
- Part of my culture/tradition□2
- I want a closer bond with my baby ...□3
- It is easier to breastfeed my baby□4
- Other□5

Please tell us: _____

65. About how many hours a day, on average, is your new baby in the same room with someone who is smoking?

_____ Hours

66. Did you enroll your new baby into a health coverage program, like Medi-Cal, Healthy Families, Healthy Kids or a private insurance, **before** leaving the hospital?

- Yes□1
- No□0

67. Has your new baby had a well-baby checkup? (A well-baby checkup is a regular health visit for your baby usually at 2, 4, and 6 months of age.)

- Yes ...□1 → GO TO QUESTION #69
- No ...□0

53. How would you describe your health **during** your pregnancy?
- Excellent☐1
- Very Good☐2
- Good☐3
- Fair☐4
- Poor☐5

Now think about the time since your new baby was born. The next questions are about you and your baby.

54. Is your baby alive now?
- Yes☐1
- No☐0
- If your baby has passed away, we would like to extend our condolences to both you and your family. Please know that we are here to offer support during your time of need. If you need any support, please call us at 1-866-706-LAMB (5262).
55. We would like to know how you felt about the care you received at the hospital **during** your last delivery. Overall, how would you rate the hospital where you delivered your new baby?
- Excellent☐1
- Very good☐2
- Good☐3
- Fair☐4
- Poor☐5

56. Did you give up your baby for adoption **after** delivery?
- Yes ... ☐1 → GO TO QUESTION #69
- No ... ☐0
57. Did you ever breastfeed or pump breast milk to feed your new baby **after** delivery?
- Yes ... ☐1 → GO TO QUESTION #59
- No ... ☐0
58. What were your reasons for not breast-feeding your new baby? **Check all that apply.**
- My baby was sick and could not breastfeed☐1
- I was sick and could not breastfeed ... ☐2
- I had too many household duties☐3
- I did not like breastfeeding☐4
- I went back to work or school☐5
- My family and/or partner did not want me to breastfeed☐6
- Other☐7
- Please tell us:** _____
- _____
- GO TO QUESTION #61
59. How many weeks or months did you breastfeed or pump milk to feed your baby?
- _____ Weeks **OR** _____ Months
- Less than 1 week☐1
- I'm still breastfeeding☐2
- ↳ IF SO, GO TO QUESTION #61

43. Did any of these things keep you from getting prenatal care as early as you wanted? For each reason, check **Y (Yes)** if it did or **N (No)** if it did not.
- a. I could not get an appointment as early as I wanted☐Y ☐N
- b. I didn't have enough money or insurance to pay for my visits .☐Y ☐N
- c. I didn't have my Medi-Cal Card☐Y ☐N
- d. I had problems finding a place that would accept my insurance or Medi-Cal☐Y ☐N
- e. I didn't know where to go for prenatal care☐Y ☐N
- f. I had no way to get to the clinic or doctor's office☐Y ☐N
- g. There was no one to take care of my children☐Y ☐N
- h. I had too many other problems to deal with☐Y ☐N
- i. I couldn't take time off from work☐Y ☐N
- j. The doctor or my health plan would not start care as early as I wanted☐Y ☐N
- k. I didn't want anyone to know I was pregnant☐Y ☐N
- l. I didn't know I was pregnant . ☐Y ☐N
- m. I couldn't find a doctor or nurse who spoke my language☐Y ☐N
- n. Other problems getting prenatal care☐Y ☐N
- Please tell us:** _____
- _____

44. How far did you travel (one way) to receive prenatal care?
- Less than 5 miles☐1
- 5-14 miles☐2
- 15-29 miles☐3
- 30-50 miles☐4
- More than 50 miles☐5
45. **During** your **first** or **second** prenatal care visit, were these part of your visit?
- a. Your blood pressure was measured☐Y ☐N ☐DON'T KNOW
- b. You gave a sample of your urine☐Y ☐N ☐DON'T KNOW
- c. Your blood was taken☐Y ☐N ☐DON'T KNOW
- d. Your height and weight were measured . ☐Y ☐N ☐DON'T KNOW
- e. You had a pelvic exam (pap smear) ... ☐Y ☐N ☐DON'T KNOW
- f. Your doctor asked about your health history☐Y ☐N ☐DON'T KNOW
- g. You had an ultrasound☐Y ☐N ☐DON'T KNOW
- h. Your doctor asked about your prenatal lead exposure ... ☐Y ☐N ☐DON'T KNOW

46. Here are some concerns that a doctor, nurse, or other health care worker may talk about during a prenatal care visit. Did they talk about these things with you? Please count only discussions, not reading materials or videos.

- a. How smoking during pregnancy could affect my baby . . .☐Y ☐N ☐DON'T KNOW
- b. Breastfeeding my baby☐Y ☐N ☐DON'T KNOW
- c. What drinking alcohol during pregnancy could do to my baby☐Y ☐N ☐DON'T KNOW
- d. Using a seat belt during my pregnancy☐Y ☐N ☐DON'T KNOW
- e. Birth control methods to use after my pregnancy . .☐Y ☐N ☐DON'T KNOW
- f. Medicines that are safe to take during my pregnancy . .☐Y ☐N ☐DON'T KNOW
- g. How using any kind of drugs could affect my baby . .☐Y ☐N ☐DON'T KNOW
- h. What to do if my labor starts early☐Y ☐N ☐DON'T KNOW
- i. Getting tested for HIV (the virus that causes AIDS) . . .☐Y ☐N ☐DON'T KNOW
- j. Physical abuse to women by their husbands/ partners☐Y ☐N ☐DON'T KNOW
- k. Getting genetic testing for chromosomal problems or neural tube defects (e.g. expanded AFP or triple markers)☐Y ☐N ☐DON'T KNOW
- l. Asked me if I felt anxious or depressed☐Y ☐N ☐DON'T KNOW
- m. Getting a flu vaccine during pregnancy☐Y ☐N ☐DON'T KNOW

- n. Getting an H1N1 vaccine during pregnancy☐Y ☐N ☐DON'T KNOW
 - o. Information about lead exposure☐Y ☐N ☐DON'T KNOW
 - p. How much weight to gain☐Y ☐N ☐DON'T KNOW
- How many pounds did your health care provider say you should gain?**
- _____ Pounds **OR** _____ Kilos

47. We would like to know how you felt about the care you received during your last pregnancy. **If you went to more than one place for prenatal care, answer for the place where you received most of your care.**

Dissatisfied		Neutral		Satisfied
	a. How long you had to wait to see the doctor at the doctor's office.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			
	b. How much time the doctor or nurse spent with you during your visits.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			
	c. The advice you received on how to take care of yourself.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			
	d. The understanding and respect that the staff showed toward you.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			

48. Did you receive these vaccines **during** your pregnancy?
- a. Seasonal flu☐Y ☐N
 - b. H1N1☐Y ☐N

49. **During** your last pregnancy, did you get any of these services?
- a. WIC☐Y ☐N ☐DID NOT NEED
 - b. Childbirth classes .☐Y ☐N ☐DID NOT NEED
 - c. Parenting classes ☐Y ☐N ☐DID NOT NEED
 - d. Classes on how to stop smoking . . .☐Y ☐N ☐DID NOT NEED
 - e. Visits to your home by a nurse or other health care worker☐Y ☐N ☐DID NOT NEED
 - f. Food stamps☐Y ☐N ☐DID NOT NEED
 - g. CalWORKS (welfare)☐Y ☐N ☐DID NOT NEED

50. Did you have any of these problems **during** your last pregnancy?
- a. High blood pressure (such as high blood pressure caused by pregnancy, preeclampsia, or toxemia) . . .☐Y ☐N
 - b. High blood sugar (gestational diabetes) that started during this pregnancy .☐Y ☐N
 - c. Labor that began too soon (labor pains more than 3 weeks before my baby was due☐Y ☐N
 - d. Membranes broke too soon (water broke more than 3 weeks before my baby was due)☐Y ☐N
 - e. Fetal growth restriction (baby not growing properly) . .☐Y ☐N
 - f. Cervix had to be sewn shut (incompetent cervix)☐Y ☐N
 - g. Problems with the placenta (such as abruptio placentae or placenta previa)☐Y ☐N

- h. Bacterial vaginosis (vaginal infection caused by bacteria)☐Y ☐N
- i. Sexually transmitted disease . .☐Y ☐N
- j. Kidney or bladder (urinary tract) infection☐Y ☐N
- k. The flu☐Y ☐N
- l. Severe nausea, vomiting, or dehydration☐Y ☐N
- m. Problems with your teeth or gums☐Y ☐N
- n. I was put on bed rest☐Y ☐N

51. This question is about the care of your teeth **during** your most recent pregnancy. For each item, check **Y (Yes)** if it is true or check **N (No)** if it is not true.

- a. I needed to see a dentist for a problem☐Y ☐N
- b. I went to a dentist or dental clinic☐Y ☐N
- c. A dental or other health care worker talked with me about how to care for my teeth and gums☐Y ☐N
- d. I had my teeth cleaned in the last year☐Y ☐N

52. For **two weeks or longer** **during** your most recent pregnancy, did you:

- a. Feel sad, empty or depressed for most of the day?☐Y ☐N
- b. Lose interest in most things like work, hobbies, and other things you usually enjoyed? . . .☐Y ☐N